

AMERICA'S HEALTH BENEFITS EXCHANGE: THE BASICS

ILLINOIS DEPARTMENT OF INSURANCE
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Overview

- Definition of an Exchange --

Exchanges are a transparent, centralized marketplace that provide access to more affordable, comprehensive health insurance coverage options to individuals and small businesses.

- Minimum Federal Requirements of an Exchange

- State Exchange Decision-Points

Definition of an Exchange

Federal Authorizing Language:

- **Section 1311** of the Patient Protection and Affordable Care Act (ACA), signed into law by President Obama on March 23, 2010, provides states with the option of and funding for the planning and establishment of an “**American Health Benefits Exchange**” (“Exchange”).

Statutory Goals of an Exchange(s):

- **Individual Market Coverage.** An Exchange must facilitate the purchase and sale of qualified health plans in the individual market.
- **Small Group Market Coverage.** A State that establishes an Exchange must also provide for the establishment of a Small Business Health Options Program (SHOP Exchange) to assist qualified small employers in facilitating the enrollment of their employees in qualified health plans offered in the small group market.
- **Other Mandatory Requirements.** An Exchange must abide by the additional requirements included in the ACA as well as related regulations.

Definition of an Exchange (cont.)

Key Dates

- **January 1, 2013:** States must demonstrate progress toward successful implementation of an Exchange, or the Secretary of Health and Human Services (HHS) will implement an Exchange in that State.
- **Fall 2013:** State Exchanges must begin with an open enrollment period for individuals and small businesses.
- **January 1, 2014:** The Exchange must be fully operational.

Exchange Operations

- The State may choose to permit the Exchange to contract with an “eligible entity” for any of its functions.
 - This could include functions such as certifying health plans for participation in the Exchange, or enrolling eligible individuals into public health care programs.
- An “eligible entity” can include:
 - Existing State Medicaid Agency;
 - Existing Department of Insurance; and/or
 - An entity with experience in benefit administration or other experience relevant to the Exchange responsibilities.
- An “eligible entity” CANNOT be a health carrier or an affiliate of a health carrier.

Federal Requirements of Exchange

Statutory Requirements

- Initial guidance from the Secretary of HHS (“Secretary”) on Exchanges, published in November 2010, highlights two basic types of federal requirements:
 1. Minimum functions of the Exchange(s); and
 2. Oversight responsibilities in certifying/monitoring the performance of “**qualified health plans.**”

Definition of a “Qualified Health Plan” as defined in Section 1301

- Certified as meeting the Secretary’s (to be defined) requirements related to: marketing, sufficient provider choice, includes essential community providers, accredited on quality performance metrics, Exchange accreditation, utilizing a uniform enrollment form, utilizes a standard format for presenting options, provides information on quality performance, and reports to the Secretary on pediatric quality measures;
- Provides the “essential benefits package” to be defined by the Secretary;
- Is offered by a health insurer that meets specific requirements (in section 1301(a)(C):
 - Licensed and in good standing with the State
 - Agrees to offer at least one silver and one gold plan in the Exchange
 - Agrees to offer the same premium for qualified health plans inside and outside the Exchange
 - Complies with any additional regulations established by HHS

Mandatory Duties of the Exchange

- ❑ Certification, recertification and decertification of health benefit plans as “qualified health plans”;
- ❑ Provide for the operation of a toll-free telephone hotline to respond to requests for assistance;
- ❑ Provide for enrollment periods (initial, annual, special, etc.);
- ❑ Maintain an Internet website through which enrollees and prospective enrollees of “qualified health plans” may obtain standardized comparative information on such plans;
- ❑ Assign a rating to each “qualified health plan” offered through the Exchange, and determine each qualified health plan’s level of coverage;
- ❑ Use a standardized format for presenting health benefit options in the Exchange;

Mandatory Duties of the Exchange

(cont.)

- ❑ Inform individuals of eligibility requirements for the Medicaid program, the Children's Health Insurance Program (CHIP) or any applicable State or local public program, and if eligible, enroll that individual in that program;
- ❑ Establish and make available by electronic means a calculator to determine the actual cost of coverage after application of any premium tax credit and any cost-sharing reduction;
- ❑ Establish a SHOP Exchange through which qualified employers may access coverage for employees;
- ❑ Grant a certification of exemption from the individual responsibility penalty;
- ❑ Transfer information to the U.S. Secretary of the Treasury;
- ❑ Provide to each employer the name of each employee who ceases coverage under a "qualified health plan" during a plan year and the effective date of the cessation;

Mandatory Duties of the Exchange

(cont.)

- ❑ Perform duties required of the Exchange by the Secretary or the Secretary of the Treasury related to determining eligibility for premium tax credits, reduced cost-sharing or individual responsibility requirement exemptions;
- ❑ Select entities qualified to serve as Navigators;
- ❑ Review the rate of premium growth within the Exchange and outside the Exchange, and consider the information in developing recommendations on whether to continue limiting qualified employer status to small employers;
- ❑ Credit the amount of any “free choice voucher” to the monthly premium of the plan in which a qualified employee is enrolled, and collect the amount credited from the offering employer;
- ❑ Consult with stakeholders relevant to carrying out the activities required in the ACA; and
- ❑ Meet financial integrity requirements specified in the ACA.

Elements of a Successful Exchange

- ❑ Successfully Manages Adverse Selection
- ❑ Attracts a Large and Diverse Pool
- ❑ Provides Choice without Complexity
- ❑ Provides Streamlined Access and Continuity of Care
- ❑ Promotes Appropriate Transparency and Accountability for Consumers
- ❑ Operates Efficiently and Communicates Effectively with Employers and Insurers
- ❑ Financially Self-Sustaining

Action in Illinois To-Date

- ❑ **Illinois Health Care Reform Implementation Council (“Council”).** Governor Quinn signed Executive Order 10-12 on July 30, 2010, thereby establishing the Council. The Council will provide recommendations to the Governor on the implementation of health reform in Illinois. Since its establishment, the Council has conducted four public hearings, the first of which focused on the Exchange.
- ❑ **Federal Planning and Establishment Grant.** On September 30, 2010, the Department of Insurance, on behalf of the State, was awarded \$1 million to work in partnership with the Governor’s office, the Department of Healthcare and Family Services, and other key State agencies and departments to evaluate and plan for the establishment of an Exchange in Illinois.
- ❑ **Request for Public Comment on Exchanges.** On November 15, 2010, the Council published a document, *Health Insurance Reform and the Option of Establishing an Insurance Exchange in Illinois*. The Department of Insurance welcomes comments at any time. Feedback can be sent to doi.healthreform@illinois.gov.
- ❑ **NAIC Exchange Model Law.** The Department of Insurance is leading NAIC’s efforts to develop model legislation and federal regulations for state-based exchanges.

Key Decision Points for Illinois

□ **Governance – Options**

1. Existing State Agency
2. Quasi-governmental Entity
3. Independent Non-profit

□ **Future of External Market for Health Insurance Outside the Exchange.**

- Rules for an External Market for Health Insurance
- Additional mechanisms to mitigate “adverse selection”

□ **Additional Functions of the Exchange (beyond the federal minimum)**

- Administrative functions for employers
- Quality-Improvement mechanisms

Organizational Considerations

- Appointment process, powers, duties and other responsibilities of Exchange entity;
- Authority and procedures for hiring staff and procurement resources;
- Responsibilities of State agencies coordinating activities with the Exchange; and
- Applicability of insurance producer/licensing requirements to the Exchange.

Key Decision Points for Illinois (cont.)

- ❑ **Financial Sustainability.** The Exchange must be financially self-sustaining beginning January 1, 2015.
 - The ACA explicitly permits States to charge assessments or user fees to health carriers, or use of some alternative financing mechanism.
- ❑ **Essential Health Benefits v. Existing State Benefit Mandates.**
 - If the State has benefit mandates that exceed the federal essential health benefit requirements, States may choose either to: 1) establish a mechanism under which qualified health plans may lawfully be offered through the Exchange without being required to provide benefits in addition to the federally designated essential benefits; or 2) establish a mechanism for evaluating and defraying the costs of the additional benefits.
- ❑ **Separate or Merged Individual and SHOP Exchanges.**
- ❑ **Regional or Interstate Exchanges.**

Key Decision Points for Illinois (cont.)

□ **Employer Definitions and Participation.**

- Definition of “Small Employer.” A small employer in Illinois employs between 2 to 50 employees. This definition must be expanded to be 100 employees beginning January 1, 2016.
- Definition of “Qualified Employer.” In 2017, the State has the option to expand the definition of a “qualified employer to include firms with more than 100 employees.

□ **Outreach and Enrollment**

- “Navigator Function.” Define the State’s approach to the “Navigator” function and consider the roles of both public and private individuals with similar experience (i.e. brokers/agents, All Kids application agents, etc.)
- Education and Outreach for Exchange for the vulnerable and underserved.

Key Decision Points for Illinois (cont.)

- **Future of Risk Adjustment and Reinsurance for Plans inside and outside the Exchange.**
 - ▣ *Risk-Adjustment.* A mechanism for spreading risk across insurance companies by taking into account the health status and health spending of enrollees in an insurance plan. The risk adjustment mechanism under the ACA will collect payments from plans with healthier, low-cost individuals and provide payments to plans with sicker, high-cost individuals.
 - ▣ *Reinsurance.* A reimbursement system that protects insurers from very high claims. It usually involves a third party paying part of an insurance company's claims once they pass a certain amount. Reinsurance is a way to stabilize an insurance market and make coverage more available and affordable. (www.healthcare.gov)